

deviation was not very marked, except in one case, where the middle turbinate was greatly enlarged. This patient gave a history of post-nasal discharge, which I discovered was from the posterior group of cells, while the other two reported a watery discharge, seldom noticed except during the attacks. In the case of the patient with the very enlarged middle turbinate, I performed a turbinectomy. In another I fractured the turbinate, and in the remaining case merely cauterised the turbinate. All were ordered a nasal spray. In each case the frequency of the attacks has been greatly reduced and the severity considerably diminished. The patient whose turbinate I fractured has had the most gratifying result. Instead of having an attack once or twice weekly, there is now an interval of about six weeks. In this case, application of the cautery when the attack is coming on seems to have an influence in checking it. This is doubly satisfactory to me, as this patient is my secretary. In this case and the case of the patient who had a turbinectomy performed, I propose to do a sub-mucous resection at a later date.

In conclusion, I wish to repeat that in investigating the cause of headache, the more usual sources having been excluded, the nose should be thoroughly examined, as in many cases it will prove to be the source of trouble, even when there are no obvious signs of nasal disease.

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REVIEW

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